16912

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County Carroll

City or town Prince Bridge (Carroll)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville R.D.
(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Howard E. Atkinson

3.(b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Minnie A.

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1895

8. AGE:

Years	Months	Days	If less than one day
50	2	15	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER — 12. Name Wm H. Atkinson

13. Birthplace Md.

MOTHER — 14. Maiden name Rose E. Harrison

15. Birthplace Md.

16. Informant Mrs. Minnie A. Atkinson

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29, 1945 (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Howard Co., Md.

16. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Nov 28 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945 at 1:15 P.M. afternoon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death — Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? —

23. SIGNATURE James T. Thomas Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10913

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State: Maryland County: Prince George's
City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ROBERT THOMAS BAILEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Colistus Bailey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 29, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	6	17	..... hrs. ..... min.

9. Birthplace: Bladensburg, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Robert Thomas
13. Birthplace: Unknown

MOTHER
14. Maiden name: Isabelle Bailey
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1945 (mooth) (day) (year)
Cemetery or crematory: Bailey's Cemetery
Location: Bladensburg, Md.
18. Funeral director: F. Vaeth & Sons
Address: Hyattsville, Md.

19. Nov. 16, 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16, 1945, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16, 1945, to Nov. 16, 1945 and that I last saw him alive on November 16, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Maryland Date signed 11-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

CERTIFICATE OF DEATH

10914

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 3 mo's, 2 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town
(If ontside city or town limits, write RURAL and give nearest town)
Street No. 1747 Mullikin Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM EDWARD BARKSDALE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept., 25, 1930

8. AGE: Years	Months	Days	If less than one day
15	1	15	hrs. min.

9. Birthplace Avavdale, Pa.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business at school
FATHER 12. Name Willaim Barksdale, Sr.
13. Birthplace Java, Várginia
MOTHER 14. Maiden name Majorie Boody
15. Birthplace Rising Sun, Md.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial Date thereof 11-13-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Calvary
Location
18. Funeral director Elroy O Wilson
Address 1000 Brantly ave
19. 11/9 19 45 Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 19 45, at 5.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7, 19 43 to Nov., 9, 19 45 and that I last saw h im alive on November 9, 19 45

Immediate cause of death	DURATION
Tuberculosis of the Spine	June 1942
Due to	
Due to	
Other conditions	

(Incindo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please nuderline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Md. Date signed 11/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 11915 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charlotte Lee Barnes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: L. Clyde Barnes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 2 - 1888

8. AGE: Years: 57 | Months: 9 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll County, Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: at home

FATHER — 12. Name: not

13. Birthplace: known

MOTHER — 14. Maiden name: Mary Slater

15. Birthplace: Maryland

16. Informant: L. Clyde Barnes

Address: New Windsor, Md R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 8 - 1945 (month) (day) (year)

Cemetery or crematory: Locust Grove Cemetery

Location: near Uniontown Md.

18. Funeral director: W. H. Hartsler & Sons

Address: Union Bridge & New Windsor Md

19. Nov 6 1945 (Date rec'd by registrar) Essie M Bowdle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1945, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1, 1945 to Nov 5 1945 and that I last saw h[illegible] alive on Nov 5 1945

	DURATION
Immediate cause of death: Uremia, cardiac failure	2 wks.
Due to: Essential hypertension, Terminal Hypertensive Cardio-vascular Disease	2 yrs.
Due to:	
Other conditions: Chronic glomerulo-nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. L. Seigman M. D. or other

Address: Union Bridge, Md. Date signed 11/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

1916

★ Reg. Diat. No. 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore (City)

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred: Methodist Home for Aged

How long in hospital or institution? 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 6. Main St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Caroline Virginia Baum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 20 - 1853

8. AGE: Years	Months	Days	If less than one day
91	11	6	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: John Francis Baum

13. Birthplace: Md

MOTHER — 14. Maiden name: Margaret Ann Frinzer

15. Birthplace: Md

16. Informant: Miss Julia Forester

Address: 2019 W. North Ave, Balto.

17. Burial, cremation, or removal? (Which?) Burial Date thereof: 11-26-45 (month) (day) (year)

Cemetery or crematory: Greenmount Cem.

Location: Baltimore

18. Funeral director: Wm. J. Tickner & Sons

Address: North & Pa. Aves. Balto. Md.

19. 11-24-45 (Date rec'd by registrar) L. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 19 45 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 20 to Nov. 24 19 45 and that I last saw h alive on Nov. 24 19 45

Immediate cause of death	DURATION
(a) Bronchopneumonia	4 days
Due to (b) Arteriosclerosis	
Due to (c)	
Other conditions: Diabetes Mell.	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. Woodward M. D. or other

Address: Baltimore Date signed: 11-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

10317

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Near Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Grace Flinda Beaver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Francis I Beaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 2 1876

8. AGE: Years	Months	Days	If less than one day
69		23	..... hrs. ..... min.

9. Birthplace: Carroll Co (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm Henry Hook

FATHER — 13. Birthplace: Carroll Co.

MOTHER — 14. Maiden name: Mary S. Ruse

MOTHER — 15. Birthplace: Carroll Co.

16. Informant: Stanley Murray Beaver

Address: Westminster Route 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28-45 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster Carroll Co

18. Funeral director: H. Bankard, Jr

Address: Westminster, Md.

19. NOV 28 1945 (Date rec'd by registrar) C R Fogle Dep Co C Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1944, to November 25 1945 and that I last saw her alive on November 25 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 da
Due to: Arteriosclerosis & Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md. Date signed 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10918

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 9 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 703 W. Mulberry St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: LOUISE BERKLEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	widowed

8.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June ? 1905

8. AGE: Years	Months	Days	If less than one day
40	5	?	hrs. min.

9. Birthplace: Snow Hill, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: George Collins
13. Birthplace: Snow Hill, Md.

MOTHER
14. Maiden name: Rachel Victor
15. Birthplace: Snow Hill, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11-16-45 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location:
18. Funeral director: H. WALSTEAD
Address: 916 Druid Hill

19. Nov. 13, 1945 (Date rec'd by registrar) Albert R. [illegible] Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1945 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1945 to Nov. 13, 1945 and that I last saw her alive on November 13, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10919

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 1 mo., 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: GERTRUDE MAE BISHOP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 25, 1919

8. AGE: Years	Months	Days	If less than one day
26	1	29	..... hrs. ..... min.

9. Birthplace: Girdletree, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: William Bishop
13. Birthplace: Girdletree, Md.

MOTHER
14. Maiden name: Elizabeth Johnson
15. Birthplace: Girdletree, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-45 (month) (day) (year)
Cemetery or crematory: Local Burying
Location: Girdle Tree, Md
18. Funeral director: Dennis Funeral Home
Address: Snow Hill, Md

19. Nov. 24, 1945 (Date rec'd by registrar) Albert A. Smith Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24, 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 11, 1943 to Nov. 24, 1945 and that I last saw her alive on Nov. 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 11-24-45.

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10920

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 5 mos, 8 days.

Hospital, institution, or street address where death occurred: Springfield State Hospital.

How long in hospital or institution? 2 yrs, 5 mos, 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newboro infants give residence of mother)

State: Maryland County: Montgomery

City or town: Barnesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If roral, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daisy May Boxall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: James Boxall 6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): October 12, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	13	...hrs. ...min.

9. Birthplace: Montgomery Co., Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: own home

FATHER — 12. Name: Thomas Dillehay

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Lottie Johnson

MOTHER — 15. Birthplace: Md.

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-45 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry West

Address: Sykesville, Md.

19. Nov. 30 1945 C. Harry West (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1945, at 9:20A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1943, to November 25 1945 and that I last saw h...er alive on November 25 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to	
Due to	
Other conditions Psychosis with cerebral Arteriosclerosis (Ioclode pregnancy within 3 months of death)	3 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: Springfield State Hosp. Date signed: 11-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-2)

CERTIFICATE OF DEATH

10921 76

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 1/2 Penn. Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas James Boylan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Sue and Davis Clement Payne

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Jan. 21 - 1876

8. AGE: Years	Months	Days	If less than one day
69	9	13	..... hrs. ..... min.

9. Birthplace: Westminster, Md. (Town, county, and state)

10. Usual occupation: Merchant, Ret.

11. Industry or business: Grocer

FATHER 12. Name: Dennis Boylan

13. Birthplace: Ireland

MOTHER 14. Maiden name: Ellen Tyndall

15. Birthplace: Md.

16. Informant: Mrs Susan Boylan

Address: 105 1/2 Penn. Ave. Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7 - 1945 (month) (day) (year)

Cemetery or crematory: St. Johns

Location: Westminster, Md.

18. Funeral director: H. Bankard & Son

Address: Westminster, Md.

19. 11/6 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1945 at 8:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Nov. 4. 1945

and that I last saw h im alive on Nov. 4 - 1945

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to Asthma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. C. Jennette M. D. or other

Address: Westminster Md Date signed: 11-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10922

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carroll

City or town Near Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Near Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Vernon S. Brower

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sarah J. Reaver Brower

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	5	14	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Warren M. Brower

13. Birthplace Md.

MOTHER 14. Maiden name Lydia L. Saylor

15. Birthplace Md.

16. Informant Mrs. Vernon Brower

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 16, 1945 (month) (day) (year)

Cemetery or crematory Reformed Cemetery

Location Taneytown, Md.

18. Funeral director C.O. Fuss & Son

Address Taneytown, Md.

19. Nov 14, 1945 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945 at 9:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Disease	-
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. Reed, Phys. Medical Examiner M. D. or other

Address Taneytown Md. Date signed 11/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

10923

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yr., 2 mo., 14 days

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 21 yr., 2 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: .....

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: Leo Joseph Brown

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1895

8. AGE: Years	Months	Days	If less than one day
50	5	7	..... hrs. ..... min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER — 12. Name: Hugh J. Brown

13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Mary A. Flynn

15. Birthplace: Baltimore City, Maryland

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal) Date thereof: Nov 21- 45 (month) (day) (year)

Cemetery or crematory: St Mary- Leen Grave

Location: Woodburn on

18. Funeral director: John G Moran

Address: 3000 E. Baltimore St

19. 11-20-45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18 1945 at 11:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943, to Nov. 18 1945 and that I last saw h. alive on November 18 1945

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration, prior to 1945	
Due to	
Due to	
Other conditions: Dementia precox, catatonic type	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May MD M. D. or other

SPRINGFIELD STATE HOSPITAL

Address: SYKESVILLE, MARYLAND Date signed: 11/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16924

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 25 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 N. Fremont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: OSCAR DAVIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 28, 1909

8. AGE:	Years	Months	Days	If less than one day
	36	4	24	hrs. min.

9. Birthplace: Randallstown, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Jacob Davis

13. Birthplace: Randallstown, Md.

MOTHER — 14. Maiden name: Cora Bowyer

15. Birthplace: Randallstown, Md.

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24-1945 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location: Brooklyn

18. Funeral director: Va Brooks Ruggold

Address: 1463 N. Carey St #1 Md

19. Nov. 22, 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1945, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1945 to Nov. 22, 1945 and that I last saw him alive on Nov. 22, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Aug. 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (945)

CERTIFICATE OF DEATH

10925

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs.Nellie M.Dern

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10,1878

8. AGE: Years	Months	Days	If less than one day
67	6	6	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation housework

11. Industry or business

FATHER 12. Name Geo.K.Duttera

13. Birthplace Md

MOTHER 14. Maiden name Jane Myerly

15. Birthplace Md.

16. Informant Carroll D.Dern

Address Taneytown,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov.18,1945. (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville,Md.

18. Funeral director C.O.FUSS & SON

Address Taneytown,Md.

19. Nov 18 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 th 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 th 1945 to Nov 16th 1945

and that I last saw h.e.r alive on Nov 15-th 1945

Immediate cause of death	DURATION
Coronary Embolism	for minutes
Due to	
Due to	
Other conditions Cardiac asthma	10 Days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D. M. D. or other

Address Taneytown Md Date signed 11/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

10926

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Florrie Dudderar

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May or June, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	?	?	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ----

FATHER
12. Name: Dennis W. Dudderar
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Anna R. Collebary
15. Birthplace: Carroll County, Md.

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 19-1945 (month) (day) (year)
Cemetery or crematory: Ebenezer Church Cemetery
Location: Westfield Maryland
18. Funeral director: D.D. Hoffler & Son
Address: Union Bridge & Glen Wardner Md

19. 11-16 1945 (Date rec'd by registrar) Attorney Keeper Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 16 1945 at 2 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1945 to November 16 1945 and that I last saw him alive on November 16 1945

Immediate cause of death	DURATION
Acute Hemorrhagic Myocarditis	½ hr.
Due to	
Due to	
Other conditions	
Senile Psychosis (Include pregnancy within 3 months of death)	5 yrs

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: S.S. Hosp. Sykesville, Md. Date signed 11-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

10927

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Not known
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter Hammer Ellingsworth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1866 ~~1866~~ (Month and day not known)

8. AGE: Years	Months	Days	If less than one day
79	?	?	hrs. min.

9. Birthplace: Wicomico County, Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ----

FATHER
12. Name: Hugh Ellingsworth
13. Birthplace: Not known

MOTHER
14. Maiden name: Lucy Williams
15. Birthplace: Not known

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-10-45 (month) (day) (year)
Cemetery or crematory: Allen's
Location: Wicomico Co. Md.

18. Funeral director: William Cook Inc.
Address: St. Paul & Preston Sts.

19. 11-8-45 (Date rec'd by registrar) 19 Nancy Kerr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7 1945, at 9.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5 1945, to Nov. 7 1945, and that I last saw him alive on Nov. 7 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Psychosis with Epilepsy	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: St. Hosp. Sykesville, Md. Date signed 11-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

10928

Reg. Dist. No. 88

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? R.D. 5
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 5
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Monroe Fletcher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 24 - 1945

8. AGE: Years: | Months: 4 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Carroll County, Md
(Town, county, and state)

10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Clinton Fletcher
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Elsie Gamrod
15. Birthplace: Maryland

16. Informant: Clinton Fletcher
Address: Westminster Md. R.D. 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 14-1945 (month) (day) (year)
Cemetery or crematory: Western Chapel Cem.
Location: near Avondale Md

18. Funeral director: H. H. Harbaugh & Sons
Address: Union Bridge & New Windsor Md

19. Nov 14 1945 (Date rec'd by registrar) Lucie S. Brandt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 11th 1945, to November 13th 1945
and that I last saw h[illegible] alive on November 13th 1945

Immediate cause of death	DURATION
Acute Bronchio-Pneumonia	3 days
Due to: Influenza	1 week
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lester Bair (M.D.)
M. D. or other
Address: Westminster Md. Date signed: 11/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10929

★ Reg. Diat. No. 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Frankfoster

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Jacob B Frankfoster Deceased
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 2, 1862
8. AGE: Years 83 | Months 8 | Days 5 | If less than one day ... hrs. ... min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business
FATHER 12. Name: George Annent
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Sophia Annie Hersh
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. Ira Frankfoster
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-10-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Wenk's Sons
Address: Manchester, Md.
19. Nov. 9 1945 (Date rec'd by registrar) Mrs. W. P. L. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 7 1945, at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1943, to Nov 7 1945 and that I last saw h-w alive on Nov 7 1945

Immediate cause of death: Chronic myocarditis DURATION? ...
Coronary sclerosis Cardio Vascular ? ...
Due to: Senile. ...
Due to: ...
Other conditions ...
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of ...
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — injured at work? —

23. SIGNATURE: Joseph E Buck M.D. (M. D. or other)
Address: Hampstead Md. Date signed 11-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

10930

Reg. Diat. No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Westminster Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 145 Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Wm. Gable Gable

3.(b) Social Security Number 212-24-5325

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minerva Gable

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1883

8. AGE: Years	Months	Days	If less than one day
62		1	..... hrs. ..... min.

9. Birthplace Carroll Co (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Anthony Gable

13. Birthplace Germany

MOTHER 14. Maiden name Mrs. Kathgunda Kastner (Gable)

15. Birthplace Germany

16. Informant Mrs. Marlin Smith

Address 145 Liberty St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 29. 45 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster Carroll Co.

18. Funeral director H. Bankard. Son

Address Westminster Md.

19. 11/28 19 45 C L Foyle Registrar

(Date rec'd by registrar)

Dep Lar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 19 45 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25 1945 to Nov. 26 19 45

and that I last saw him alive on Nov 26 19 45

Immediate cause of death	DURATION
Acute Cardiac Dilatation	4 hrs
Due to Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edwin R Fauntz M.D. M.D. or

Address Westminster Md Date signed 11-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10931

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 28 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro lofants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or towo limits, write RURAL and give neorest town)
Street No. 1036 Hillen Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HELEN GOODMAN

3.(b) Social Security Number: 216-20-5652

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Febuary 17, 1923

8. AGE:	Years	Months	Days	If less than one day
	22	7	17	hrs. min.

9. Birthplace: Suffolk, Va.
(Town, county, and state)
10. Usual occupation: Worker in Sewing Factory
11. Industry or business

FATHER
12. Name: John Goodman
13. Birthplace: Suffolk, Va.

MOTHER
14. Maiden name: Mary Lawrence
15. Birthplace: Suffolk, Va.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/7/45 (month) (day) (year)
Cemetery or crematory: Mt Calvery
Location: Brooklyn, Md.
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley Ave

19. 11/3 (Date rec'd by registrar) 19 45 Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 1945, at 4.25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945 to Nov., 3, 1945 and that I last saw her alive on November 3, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 15, 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findiogs of operatioos: Date of op.
Autopsy results
PHYSICIAN: Please noderlioe the caose to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M. D.
M. D. or other
Address: Henryton, Md. Date signed 11/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10932

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 25 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 632 N. Gilmor Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: HELEN PINDELE GOODWIN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married (Sep)

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19, 1921

8. AGE:	Years	Months	Days	If less than one day
	24	8	20	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Professional Dancer
11. Industry or business
FATHER 12. Name: Edward H. Pindele
FATHER 13. Birthplace: Parole, Md.
MOTHER 14. Maiden name: Violet Smith
MOTHER 15. Birthplace: Baltimore, Md.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore, Md.
18. Funeral director: Jesse W. Bedden
Address: 436 W. Biddle St
19. 11/8 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 19 45, at 6.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept., 14, 19 45 to Nov., 8, 19 45 and that I last saw her alive on November 8, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 11/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

10933

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Hyattsville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4708 Rhode Island Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ROSCOE HAYES

3. (b) Social Security Number: 579-16-0582

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Hattie Hayes
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): February 5, 1910

8. AGE: Years	Months	Days	If less than one day
35	9	19	....hrs. ....min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Joe Hayes
13. Birthplace: Greenberg, N.C.

MOTHER
14. Maiden name: Minnie Munk
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 29, 1945 (month) (day) (year)
Cemetery or crematory: Methodist Cem.
Location: Bladensburg, Md.

18. Funeral director: F. Gaschi Sons
Address: Hyattsville, Md.

19. Nov. 24, 1945 (Date rec'd by registrar) Albert L. Bradshaw Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12, 1945, to Nov. 24, 1945 and that I last saw h im alive on Nov. 24, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 11-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

10934

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Carroll

City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Springfield State Hospital
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: William N. Hilding

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 22, 1868

8. AGE: Years	Months	Days	If less than one day
77	6	15	____ hrs. ____ min.

9. Birthplace: Sweden
(Town, county, and state)

10. Usual occupation: tailor

11. Industry or business:

FATHER — 12. Name: Andrew Hilding
13. Birthplace: Sweden

MOTHER — 14. Maiden name: Unknown
15. Birthplace: Sweden

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 10, 1945 (month) (day) (year)

Cemetery or crematory: Springfield

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov. 9, 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1945, at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1945, to November 7, 1945, and that I last saw h IM alive on November 7, 1945.

	DURATION
Immediate cause of death: Cerebral hemorrhage	48 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
SPRINGFIELD STATE HOSPITAL, M.D. or other
Address: SYKESVILLE, MARYLAND Date signed 11-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 12 days

Hospital, Institution, or street address where death occurred: SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 3 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Maple Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John Joseph Hoban

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	married

6.(b) Name of husband or wife: Mary Hayes

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): August 14, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	16	....hrs. ....min.

9. Birthplace: Lonaconing, Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Auto tire manufacturing

FATHER — 12. Name: John Hoban

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Laura Sheriff

MOTHER — 15. Birthplace: Virginia

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-45 (month) (day) (year)

Cemetery or crematory: St. Michaels Cem.

Location: Frostburg, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Nov. 30 1945 C. Harry Weer (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1945, 11:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1945 to Nov. 29 1945 and that I last saw h IM alive on Nov. 29 1945

Immediate cause of death	DURATION
General paralysis of the Insane, prior to December,	1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): ....

Means of injury: ....Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

SPRINGFIELD STATE HOSPITAL M. D. or other

Address: SYKESVILLE, MARYLAND Date signed 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10936

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo's, 21 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

CATHERINE CHRISTINE JOHNSON

3.(b) Social Security Number

213-24-1246

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1927

8. AGE:

Years	Months	Days	If less than one day
18	5	6	..... hrs. ..... min.

9. Birthplace: Easton, Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: at school

FATHER
12. Name: Walter Johnson
13. Birthplace: Easton, Md.

MOTHER
14. Maiden name: Emma Johnson
15. Birthplace: Easton, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-45 (month) (day) (year)

Cemetery or crematory: Easton, Md.

Location

18. Funeral director: Mrs. Frances A. Hemsley

Address: 578 W. Biddle St

19. 11/7 (Date rec'd by registrar) 19 45 Albert Reinhardt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 7, 1945, at 6.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945, to Nov., 7, 1945 and that I last saw her alive on Nov., 7, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M. D. M. D. or other

Address: Henryton, Md. Date signed 11/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10937

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 YEARS

Hospital, institution, or street address where death occurred:

CARROLL HOME OF THE AGED

How long in hospital or institution? 3 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER, MD.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: W. MAIN ST.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: A. MAY JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 4, 1868

8. AGE:

Years	Months	Days	If less than one day
77	9	18	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: HOUSE WORK

11. Industry or business:

FATHER

12. Name: J. MONROE JONES

13. Birthplace: MARYLAND

MOTHER

14. Maiden name: MATILDA BOSWELL

15. Birthplace: MARYLAND

16. Informant: GEORGE W. JONES

Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/25/45 (month) (day) (year)

Cemetery or crematory: OAKLAND CEMETERY

Location: CARROLL COUNTY, MD.

18. Funeral director: C. HARRY WEER

Address: SYKESVILLE, MD.

19. 11/23/45 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOVEMBER 22 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April, 1945, to Nov 22 1945

and that I last saw her alive on Nov 22 1945

Immediate cause of death	DURATION
Cardio Vascular Renal Disease, Hypertension	several yrs
Myocardial Degeneration	4 yrs
Due to: Old Age Senility	2 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Md. Date signed 11/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10938

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 4 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2102 N. Howard St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BOOKER THOMAS JONES

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1927

8. AGE:	Years	Months	Days	If less than one day
	18	0	29	hrs. min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Carpenter Jones

13. Birthplace: Dames Quarter, Maryland

MOTHER — 14. Maiden name: Helen Pate

15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: Nov 29 1945 (month) (day) (year)

Cemetery or crematory: Dames Quarter

Location:

18. Funeral director: Adolphus Hall

Address: 918 Druid Hill Ave

19. Nov. 26, 1945 (Date rec'd by registrar) Albert R. Swadley Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26, 1945, at 1:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22, 1945, to Nov. 26, 1945 and that I last saw him alive on Nov. 26, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.

M. D. or other

Address: Henryton, Md. Date signed: 11-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10939

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Born 1 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? Born 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2620 East Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Lambert Kalendek

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 2-1920

8. AGE: Years: 25 | Months: 2 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business:

FATHER — 12. Name: John Kalendek

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden name: Anna Jagielska

MOTHER — 15. Birthplace: Poland

16. Informant: Mrs Anna Kalendek

Address: 2620 East Ave Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30 - 45 (month) (day) (year)

Cemetery or crematory: Holy Rosary

Location: Balto. Co.

18. Funeral director: Wm. S. Fialkowski

Address: 2007 Eastern Ave

19. 12/1/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1945 at 2-10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7th 1944 to Nov 26 1945 and that I last saw him alive on Nov 26th 1945

Immediate cause of death	DURATION
Lobar Pneumonia	5 da
Due to: Epilepsy	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville, Md. Date signed: 12/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10940

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 25 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 405 N. Carrollton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM OSCAR KEETER

3.(b) Social Security Number: 228-01-1067

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Irene Keeter

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): December 25, 1894

8. AGE:	Years	Months	Days	If less than one day
	50	10	28	...hrs. ...min.

9. Birthplace: Rutherford County, N.C. (Town, county, and state)

10. Usual occupation: Defense Worker

11. Industry or business:

FATHER — 12. Name: Sherman Keeter

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Minnie Hampton

MOTHER — 15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-26-45 (month) (day) (year)

Cemetery or crematory: Arbutus mem. Park

Location: Balto. md

18. Funeral director: William A. Jackson

Address: 916 Penn Ave Balto md

19. Nov. 23, 1945 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 1945 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1945 to Nov. 23, 1945 and that I last saw him alive on Nov. 23, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10941

★ Reg. Diat. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Carroll 40

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2408 Frederick Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME Howard Knudsen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel A. Knudsen

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): October 27, 1890

8. AGE: Years	Months	Days	If less than one day
54	-	8	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Bethelehem Steel Co.

FATHER 12. Name: Andrew R. Knudsen

13. Birthplace: Norway

MOTHER 14. Maiden name: Unknown

15. Birthplace: Maryland.

16. Informant: Mrs Ethel A. Knudsen

Address: 2408 Frederick Ave. Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 7, 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore Md.

18. Funeral director: George L. Schwab

Address: 2101 Frederick Ave. Balto. Md

19. 11/5/45 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4 1945 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work? .....

23. SIGNATURE: James T. Ward Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed 11/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-3)

10942

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs 3 mos 11 da

Hospital, Institution, or street address where death occurred: Spring Field State Hospital

How long in hospital or institution? 13 yrs 3 mos 11 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. 5109 Pennington Ave (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Paul Kotchen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Oct 10th - 1906

8. AGE:

Years	Months	Days	If less than one day
39	8	29	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: —

FATHER — 12. Name: Michael Kotchen

FATHER — 13. Birthplace: Austria

MOTHER — 14. Maiden name: Elizabeth Roman

MOTHER — 15. Birthplace: Austria

16. Informant: Mrs Elizabeth Kotchen

Address: 5109 Pennington Ave

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 11-12-1945 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: A. A. Co. Md.

18. Funeral director: Flynn & Fleming

Address: 426 Light St.

19. 11/10 19 45 A.D. Hedrick Sr. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 8th 1945, at 8-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28th 1932, to Nov 8th 1945 and that I last saw h[illegible] alive on Nov 8th 1945

Immediate cause of death	DURATION
Carcinoma of tongue	4 yrs
Due to Paralysis	5 yrs
Due to Epilepsy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: W. F. Wastin M.D. M.D. or other

Address: Sykesville Date signed: 11/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-D)

CERTIFICATE OF DEATH

10947 96 Reg. Diat. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 128 Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MRS. ELSIE OLIVA LAUGHMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Peter Laughman
6.(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): July 9, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	4	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: George W. Harn
13. Birthplace: Maryland
MOTHER 14. Maiden name: Catherine Molesworth
15. Birthplace: Maryland
16. Informant: Mr. Peter Laughman
Address: 128 Penna. Ave., Westminster, Md.
17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 11-16-45 (month) (day) (year)
Cemetery ~~or crematory~~: Taylorsville
Location: Taylorsville, Carroll Co. Md.
16. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. 11/16/45 (Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 13th 1945, at 6.50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Nov. 13 1945
and that I last saw h~~er~~ alive on Nov. 13 1945

Immediate cause of death	DURATION
acute cardiac dilatation	2 hrs
Due to: arteriosclerosis	5 yrs
Due to: Chronic myocarditis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lelas R Fout MD M. D. or other
Address: Westminster Md. Date signed 11-13-45

10944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 746

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John L. Leister

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Flora Arnold Leister

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 25, 1891

8. AGE:	Years	Months	Days	If less than one day
	54	3	13	hrs. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual occupation: Restauranteer

11. Industry or business

FATHER 12. Name: Jesse M. Leister

13. Birthplace: Md

MOTHER 14. Maiden name: Cora J. Lawyer

15. Birthplace: Md

16. Informant: Mrs. Flora Leister

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: Taneytown, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Nov. 8, 1945 (Date rec'd by registrar) Mary B. Hilt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7th 1945, at 4:32 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3rd 1945, to Nov. 7th 1945 and that I last saw him alive on Nov. 6th 1945

Immediate cause of death	DURATION
Angina Pectoris	4 days
Due to	
Due to	
Other conditions: High Blood Pressure	1 Year

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. M. Benner M.D.
M. D. or other

Address: Taneytown Md. Date signed 11/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

10945

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 41½ Liberty
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Marshall Enias Lindsay

3.(b) Social Security Number 219-01-3106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Fannie Irene Baile

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 17 - 1867

8. AGE: Years	Months	Days	If less than one day
78	7	18	....hrs. ....min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Supt. Water works Co. Ret.

11. Industry or business

FATHER 12. Name Columbus Lindsay

13. Birthplace Md.

MOTHER 14. Maiden name Margaret ~~Ann~~ Bloom

15. Birthplace Md.

16. Informant Roger Lindsay

Address 41½ Liberty St Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 9-1945 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location New Windsor, Md.

18. Funeral director H Bankard & Son

Address Westminster Md.

19. 11/6 19 45 Edward [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 19 45 at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to Nov. 5 19 45 and that I last saw him alive on Nov 5 19 45

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Thomas M. D. or other

Address Westminster Md. Date signed Nov 6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

10946 74

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 6 mos. 7 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 yrs. 6 mos. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME

Laura Lockard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 9, 1911

8. AGE: Years	Months	Days	If less than one day
34	10	0	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

FATHER 12. Name Henry Lockard

13. Birthplace Maryland

MOTHER 14. Maiden name Laura Alexander

15. Birthplace Maryland

16. Informant Records of Springfield Hospital

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof NOV 13 1945 (month) (day) (year)

Cemetery or crematory Methodist

Location North East Md

18. Funeral director Joseph R. Lowe

Address North East

19. Nov. 9th, 1945 (Date rec'd by registrar) C. Harry Mears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1945 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1942 to November 9 1945 and that I last saw h..... alive on November 9 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to	
Due to	
Other conditions Pyelonephritis Organic Brain Disease, Symptomatic Epilepsy (Include pregnancy within 3 months of death)	3 yrs.

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eichert, M.D. M. D. or other

Address S. S. Hosp. Sykesville, Md. Date signed 11-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10947

CERTIFICATE OF DEATH

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ELSIE C. MAYNARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: J. Thomas Maynard

6.(c) If alive, give age: 85 years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1872

8. AGE: Years: 73 | Months: 2 | Days: 10 | If less than one day: ...hrs. ...min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Noah Barnes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Louisa Franklin
15. Birthplace: Maryland

16. Informant: Mr. J. Thomas Maynard
Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: 11-29-45 (month) (day) (year)

Cemetery ~~or crematory~~: Central

Location: Central, Frederick Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md

19. 11/28/45 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26, 1945, at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw her alive on Nov. 26 1945

Immediate cause of death	DURATION
Pulmonary edema	2 da
Due to: Myocardial insufficiency	2 da
Due to: Chr. Myocarditis	? yrs
Other conditions: Chr. Hypertrophic arthritis	? yrs
General Arterio-sclerosis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Mt Airy, Md. Date signed: 11/27/45

10948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 year
Hospital, institution, or street address where death occurred:
22½ Westmoreland St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22½ Westmoreland St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah Katherine Maynard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Theodore Maynard
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 27, 1894

8. AGE: Years	Months	Days	If less than one day
51	7	29	..... hrs. ..... min.

9. Birthplace: South Africa (Town, county, and state)
10. Usual occupation: Home-wife & author
11. Industry or business

FATHER
12. Name: Patrick Casey
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Lennon
15. Birthplace: Ireland

16. Informant: Miss Rosemary Maynard
Address: 22½ Westmoreland St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/28/45 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Westminster, Md.

18. Funeral director: J. E. Myers, Jr.
Address: Westminster Md.

19. 11/26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26 1945, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to Nov. 26, 1945 and that I last saw h.. alive on Nov. 24 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. Reese Holmes M. D. or other
Address: Westminster Date signed: 11-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10949

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 863 W. Fayette Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Harvey Clifton Meredith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	unknown

6.(b) Name of husband or wife: Mrs. Atkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Wilmington, Delaware (Town, county, and state)

10. Usual occupation: druggist

11. Industry or business: retail drug

FATHER — 12. Name: Henry Meredith

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Mary Jester

MOTHER — 15. Birthplace: Unknown

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27, 1945 (month) (day) (year)

Cemetery or crematory: Springfield State Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Henry Klee

Address: Sykesville, Md.

19. Nov. 27 1945 (Date rec'd by registrar) C. Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1945 at 3:40p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945 to Nov. 23 1945 and that I last saw h IM alive on November 23 1945

Immediate cause of death	DURATION
Arteriosclerosis, prior to	1943
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.

SPRINGFIELD STATE HOSPITAL M. D. or other

Address: SYKESVILLE, MARYLAND Date signed 11-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11512

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Diat. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Larry Eugene Milberry

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10 - 1945

8. AGE:

Years	Months	Days	If less than one day
-	4	8	..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Martin Hammond

13. Birthplace: Maryland

MOTHER

14. Maiden name: Thelma Milberry

15. Birthplace: Maryland

16. Informant: Thelma Milberry

Address: Union Bridge Md R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20 - 1945 (month) (day) (year)

Cemetery or crematory: Keys Chapel - Old Field

Location: Near Libertytown Maryland

18. Funeral director: D. D. Hartter & Sons

Address: Union Bridge & New Windsor Md.

19. Nov. 20 1945 (Date rec'd by registrar) J. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18 1945, at 8.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1945, to Nov 18 1945

and that I last saw h.. alive on Nov 17 1945

Immediate cause of death	DURATION
Bronchopneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed 11-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH B 10950

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 14 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1304 E. Monument St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ALMA MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1930

8. AGE:	Years	Months	Days	If less than one day
	14	11	4	hrs. min.

9. Birthplace: Ahoskie, N.C.
(Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:

FATHER
12. Name: Willis Mitchell
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Ozella McGlone
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 15-1945 (month) (day) (year)
Cemetery or crematory Mt Calvary Cemetery
Location A A Co, Md
18. Funeral director Robert E. Williams
Address 15-15 McElderry St

19. Nov. 12, 1945 (Date rec'd by registrar) Albert A. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12, 1945 at 9:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28, 1945 to Nov. 12, 1945 and that I last saw her alive on November 12, 1945

Immediate cause of death	DURATION
Tuberculous Meningitis	Oct. 29, 1945
Due to: Pulmonary Tuberculosis	Feb. 1945
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
Address: Henryton, Md. M. D. or other
Date signed: 11-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10951

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 8 days.
Hospital, institution, or street address where death occurred:
Springfield State H osp.
How long in hospital or institution? 2 mos., 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 229 Willow Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nellie Moore

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: James M. Moore
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1856

8. AGE: Years	Months	Days	If less than one day
89	4	7	hrs. min.

9. Birthplace: New York
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home
FATHER 12. Name: M. Wilson
13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
15. Birthplace:
16. Informant: hospital records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 4, 1945 (month) (day) (year)
Cemetery or crematory: Sonistota Cemetery
Location: Sonistota, S Dakota.
18. Funeral director: Withers & Walters
Address: 254 Carroll Ave. N.W. Takoma Park, D.C.
19. Nov. 29 1945 (Date rec'd by registrar) C. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1945 at 5:05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21 1945 to November 29 1945
and that I last saw her alive on November 29 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to:	
Due to:	
Other conditions: Senile Psychosis	1½ yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other
Address: S.S. Hosp. Sykesville Md. Date signed: 11-29-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1450

CERTIFICATE OF DEATH

10952

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Carroll

City or town: Prince - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution or street address where death occurred: Pleasant Valley

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Prince - Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pleasant Valley

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Upton Emmanuel Myers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Mary Patsy Myers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 25, 1878

8. AGE:

Years	Months	Days	If less than one day
67	8	29	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md.

(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER

12. Name: David S. Myers

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary J. Myers

15. Birthplace: Maryland

16. Informant: Mary Patsy Myers

Address: Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27. 45 (month) (day) (year)

Cemetery or crematory: Pleasant Valley

Location: Pleasant Valley

18. Funeral director: C. O. Fuss & Ed Hood

Address: Taneytown Md.

19. Nov 24 1945 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION above.

20. DATE OF DEATH: November 24 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Suffocation - Hanging	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Suicide Date of Nov 24-1945

Where did injury occur? Carroll Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Hanging by neck Injured at work? No

23. SIGNATURE James T. Shorah Deputy Medical Examiner

M. D. or other

Address Westminster Md. Date signed 11/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

10953

Reg. Dist. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Sunwood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Sunwood (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3. (a) FULL NAME: Ira Caylor Otto

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Bessie M. Otto

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 14 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	1	11		

9. Birthplace: Carroll County, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: John Otto

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Caylor

15. Birthplace: Maryland

16. Informant: Mrs. Bessie M. Otto

Address: Sunwood Md. R. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 27-1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cem.

Location: Uniontown Road

18. Funeral director: D. D. Feeser & Sons

Address: Union Bridge & New Windsor, Md.

19. Nov 27 1945 (Date rec'd by registrar) Margaret R. Engle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1945 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 1945 to Nov 25 1945 and that I last saw him alive on Nov 25 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	3 hrs.
Due to: arteriosclerosis	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

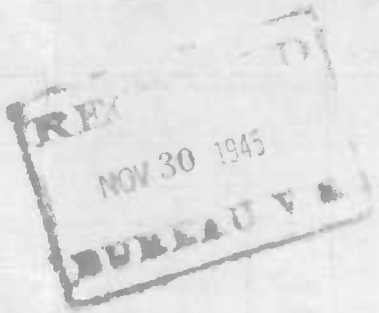
23. SIGNATURE: James T. Roark M. D. or other

Address: Westminster Md. Date signed 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


NOV 30 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

10954 Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural, near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Western Chapel near Avondale
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Levi Perry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	widowed

6.(b) Name of husband or wife: Malinda Perry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
About 70	—	-		

9. Birthplace: Nash Co. North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Levi Perry
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Jemps?
15. Birthplace: North Carolina

16. Informant: David Perry
Address: Westminster, R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/30/45 (month) (day) (year)
Cemetery or crematory: Western Chapel Cem.
Location: Rural near Westminster Md.

18. Funeral director: J. E. Mayers, Jr.
Address: Westminster, Md.

19. 11/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1945 to Nov. 28 1945 and that I last saw h alive on Nov. 27 1945

	DURATION
Immediate cause of death: Chronic Nephritis	2 yrs +
Due to: arteriosclerosis	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E Reese Wilkens, M. D. or other
Address: Westminster Date signed: 11/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10955

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 2 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 136 Chestnut Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: EDDIE RICE

3. (b) Social Security Number: 579-24-0721

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 15, 1927

8. AGE: Years	Months	Days	If less than one day
18	4	6	..... hrs. ..... min.

9. Birthplace: Duquesne, Pennsylvania
(Town, county, and state)

10. Usual occupation: Machine Operator

11. Industry or business

FATHER
12. Name: Robert Rice
13. Birthplace: Blacksfock, N.C.

MOTHER
14. Maiden name: Annie Foster
15. Birthplace: Wooden, S.C.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-24-45 (month) (day) (year)
Cemetery or crematory: Winnsboro, South Carolina
Location
18. Funeral director: Elroy C. Wilson
Address: 1000 Brantly ave

19. Nov. 21, 1945 (Date rec'd by registrar) Albert R. Swanham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 21, 1945, at 9:30P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1945, to November 21, 1945 and that I last saw him alive on Nov. 21, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 11-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10956

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6yrs. 4mos. 6 days

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 6 yrs. 4 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 904 S. Baylis St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Matilda Seibert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white ~~white~~	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 7-27-1899

8. AGE: Years	Months	Days	If less than one day
46	3	8	____ hrs. ____ min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Machine operator

11. Industry or business

FATHER
12. Name: Frederick Seibert
13. Birthplace: Unknown

MOTHER
14. Maiden name: Henrietta
15. Birthplace: Unknown

16. Informant: Records of Springfield Hosp.
Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 5 1945 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore, Md.

18. Funeral director: John W. Ulrich

Address: 2068 Orleans St.

19. Nov. 5 1945 (Date rec'd by registrar) C. Harry Ulrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1945 at 1:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 1939, to Nov 5 1945

and that I last saw h[illegible] alive on Nov. 5 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D.
M. D. or other

Address S. S. Hosp., Sykesville, Md. Date signed 11-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-6)

CERTIFICATE OF DEATH

11,957

Reg. Dist. No. 75

1. PLACE OF DEATH:

County: Carol

City or town: Finebro, Md Rd No 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Carol

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Finebro, Md #1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JANET KATHRYN SHAFFER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23. 1933

8. AGE: Years	Months	Days	If less than one day
12	5	5	hrs. min.

9. Birthplace: Carol Co. Md

(Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER 12. Name: Denton M. Shaffer

13. Birthplace: Carol Co. Md.

MOTHER 14. Maiden name: Amelia Myers

15. Birthplace: Hanover Pa

16. Informant: Delton M. Shaffer

Address: Finebro, Md Rt #1

17. (Burial, cremation, or removal, which?) Burial Date thereof: Nov. 30, 1945 (month) (day) (year)

Cemetery or crematory: Black Rock, Pa

Location: Finebro, Md R.D

18. Funeral director: Harry C. Seifert

Address: Glen Rock, Pa

19. Nov. 29 1945 (Date rec'd by registrar) Mrs. W. R. Downes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28 1945, at 1.15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1940 to 11-28 1945 and that I last saw h.er alive on 11-27 1945

Immediate cause of death	DURATION
Rheumatic Heart disease	8 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Partenfield M. D. or other

Address: Hampstead Md Date signed: 11-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10958

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 4 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 760 West Redwood St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ISAAC SHERROD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 19, 1923

8. AGE: Years	Months	Days	If less than one day
22	9	28	..... hrs. ..... min.

9. Birthplace: Talbert, North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Roland Sherrod
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Roberta Howard
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/21/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A. A. Co., Md.
18. Funeral director: Isaac L. Brown & Son
Address: 108 W. Montgomery

19. Nov. 17, 1945 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17, 1945, at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 1945, to Nov. 17, 1945 and that I last saw him alive on November 17, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 11-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Name: Lee John Crist 1/15/53 yr

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

10959

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Harney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaiah T. Shildt Schildt

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Emma Jane Shildt

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	6	hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Painter & Paper Hanger

11. Industry or business

FATHER — 12. Name William Shildt Schildt

13. Birthplace Md

MOTHER — 14. Maiden name Sophia Bostian

15. Birthplace Md

16. Informant Charles M.A. Shildt Schildt

Address Taneytown R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/20/45 (month) (day) (year)

Cemetery or crematory Lutheran

Location Taneytown, Md.

16. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Nov 21 19 45 (Date rec'd by registrar) Mary B. Hilt Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 19 45, at 8:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug. 10 19 45, to Nov. 16 19 45 and that I last saw h[illegible] alive on Nov. 16 19 45

Immediate cause of death	DURATION
chronic myocardiak disease	5 yrs
Due to	
Due to	
Other conditions Terminal pneumonia	3 months

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Donald O. Coover M.D. M. D. or other

Address Littlestown Pa Date signed 11-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10960

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 8 mo., 14 days

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 1 yr., 8 mo., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore City

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3317 Beech Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Garland Whittington Simpson

3.(b) Social Security Number: 216-10-6361

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	divorced

6.(b) Name of husband or wife: Stella Orr

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 26, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	11	____ hrs. ____ min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Bookkeeper.

11. Industry or business: Fish Rubber Co

FATHER
12. Name: John W. Simpson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary J. Barber
15. Birthplace: Maryland

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS
Address: SYKESVILLE, MARYLAND

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Nov. 19, 1945 (month) (day) (year)

Cemetery or crematory: Loudon Park.

Location: Frederick Rd.

18. Funeral director: Schnauth & Dannemann

Address: 3615-17 Chestnut Ave.

19. Nov 17 1945 (Date rec'd by registrar) Harry Steen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 19 45 10:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 21 19 ____ to Nov. 17 19 45 and that I last saw him alive on November 17 19 45

Immediate cause of death	DURATION
Cerebral thrombosis	Instant
Due to: Syphilis	43 yrs.
Due to:	
Other conditions: General paralysis of the insane	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
SPRINGFIELD STATE HOSPITAL M. D. or other
Address: SYKESVILLE, MARYLAND Date signed 11-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

10961

Reg. Diet. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ridgeville
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: R. D. Mt. Airy
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MINNIE V. SNYDER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Benedict B. Snyder
6.(c) If alive, give age: 71 years
7. Birth date of deceased (mo., day, yr.): Sept. 6, 1880

8. AGE:

Years	Months	Days	If less than one day
65	2	17	...hrs. ...min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Elhanan Haines
13. Birthplace: Maryland

MOTHER
14. Maiden name: Edith A. Kelly
15. Birthplace: Maryland

16. Informant: Mr. Benedict B.Snyder
Address: Mt. Airy, Maryland

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 11-26-45 (month) (day) (year)
Cemetery ~~or crematory~~: Pine Grove
Location: Mt. Airy, Carroll Co. Maryland

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. Nov. 26 1945 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23, 1945, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June, 1924, to Nov. 23 1945 and that I last saw h.. alive on Nov. 22 1945

	OURATION
Immediate cause of death: Coronary embolism	1 day
Due to:	
Due to:	
Other conditions: Chr. Arthritis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed 11/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

10962

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest towu)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Hurlock

(If outsido city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LULA MAE SPRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Leroy Spry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25, 1915

8. AGE:	Years	Months	Days	If less than one day
	30	3	9	..... hrs. ..... min.

9. Birthplace: Hulock, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Walter Dotson

13. Birthplace: Hurlock, Md.

MOTHER — 14. Maiden name: Hattie Cornish

15. Birthplace: Hurlock, Md.

18. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6, 1945 (month) (day) (year)

Cemetery or crematory: Petersburg Cemetery

Location: Petersburg, Md.

18. Funeral director: J. J. Frampton & Son.

Address: Middlesburg, Md.

19. Nov. 4, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4, 1945 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31, 1945 to Nov. 4, 1945 and that I last saw her alive on November 4, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 4, 1944

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 11-4-45.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10963

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 27 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 642 Smithson St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: BENJAMIN STERLING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Eugenia Sterling

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1899

8. AGE:	Years	Months	Days	If less than one day
	45	11	0	hrs. min.

9. Birthplace: West Indies
(Town, county, and state)

10. Usual occupation: Insurance Agent

11. Industry or business

FATHER
12. Name: George Sterling
13. Birthplace: West Indies

MOTHER
14. Maiden name: Matilda Hamming
15. Birthplace: West Indies

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-'45 (month) (day) (year)

Cemetery or crematory: Mt. Auburn Cem.

Location: Baltimore Md.

18. Funeral director: Mrs Katie Williams

Address: 322 Schroeder St.

19. Nov. 25, 19 45 (Date rec'd by registrar)

Albert R. Stansbury Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25, 19 45 at 7:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28, 19 45 to Nov. 25, 19 45 and that I last saw him alive on November 25, 19 45

	DURATION
Immediate cause of death: Tuberculosis of the Spine	April 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other

Address: Henryton, Md. Date signed 11-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-B)

10964

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 8 days

Hospital, Institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 1 year, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Carroll

City or town: Rural - Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George W. Stonesifer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	widowed

6.(b) Name of husband or wife: Fannie Hetlebridle

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 22, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	16	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: agriculture

FATHER 12. Name: William Stonesifer

13. Birthplace: Maryland

MOTHER 14. Maiden name: Fannie Hetlebridle

15. Birthplace: Maryland

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/11/45 (month) (day) (year)

Cemetery or crematory: Baust Cemetery

Location: Mt. Taneytown, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. 11-8-45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 19 45 at 10:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 30 19 44, to Nov. 8 19 45 and that I last saw h IM alive on November 8 19 45

Immediate cause of death	DURATION
Senility	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robt Bertrand May M.D.

SPRINGFIELD STATE HOSPITAL M. D. or other

Address: SYKESVILLE, MARYLAND Date signed: 11-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10365

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL NEAR SYKESVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 8 mo., 22 days

Hospital, institution, or street address where death occurred:
SPRINGFIELD STATE HOSPITAL

How long in hospital or institution? 1 yr., 8 mo., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Prince George's

City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carl Wanitchka

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	

B.(b) Name of husband or wife: Unknown

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
unknown			..... hrs. ..... min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: SPRINGFIELD STATE HOSPITAL RECORDS

Address: SYKESVILLE, MARYLAND

17. Removal (Burial, cremation, or removal. Which?) Date thereof Nov. 11th 1945 (month) (day) (year)

Cemetery or crematory

Location: Washington, D.C.

18. Funeral director: Frank Eniss Sowles

Address: Washington D C

19. Nov. 11, 1945 (Date rec'd by registrar) A Harry Green Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 19 45 at 8:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18-44 19 ..... to 11-10-45 19 .....

and that I last saw h IM alive on 11-10-45 19 .....

	DURATION
Immediate cause of death: Senility	3 yrs.
Due to:	
Due to:	
Other conditions: Senile psychosis, simple deterioration	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

ROBERT BERTRAND MAY, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
SPRINGFIELD STATE HOSPITAL M/D. or other
Address: SYKESVILLE, MARYLAND Date signed 11-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10966

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 7 mos 3 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 15 yrs 7 mos 3 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Montg

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie M Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Aug 23 1873

8. AGE: Years: 72 Months: 3 Days: 2 If less than one day: ... hrs. ... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: Benjamin Williams

13. Birthplace: Wales, Eng.

MOTHER — 14. Maiden name: Mary A Richardson

15. Birthplace: Washington D.C.

16. Informant: Charles W Bylander

Address: 13 7th St Wash.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 28 1945 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D.C.

18. Funeral director: Warden E. Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Nov 26 1945 (Date rec'd by registrar) C. Harry Edwards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 26 1945 at 4-50 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jul 22 1939 to Nov 26 1945 and that I last saw her alive on Nov 26 1945

Immediate cause of death	DURATION
Lobar Pneumonia	15 da
Due to:	
Due to: Arterio Sclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: W H Gaston M.D. M. D. or other

Address: Sykesville, Md. Date signed: 11-26-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

10967

Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Melrose
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Melrose
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Jonas E Witter

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Martha Witter (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27. 1863

8. AGE: Years 82 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland, Carroll Co.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Emanuel Witter
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan Myers
15. Birthplace: Maryland

16. Informant: Mrs. Calvin A. Weldasier
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-30-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Bachmansville Md

18. Funeral director: Jacob Winks Sons
Address: Manchester Md

19. Nov. 29 1945 Mrs. W. P. S. Demmer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Nov 27 1945 and that I last saw h— alive on Nov 17 1945

Immediate cause of death	DURATION
Chronic myocarditis	?
Due to: Generalized Arteriosclerosis	
Cardio-Renal Vascular Disease	
Due to: Senile.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Jos. E. Buck M.D.
M. D. or other
Address: Hampstead Md Date signed 11-28-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10968

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

182 W. Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 182 ~~Longwell~~ W. Main St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Ezra Wolf

3. (b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife Virginia Hesson Wolf

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21, 1869

8. AGE: Years	Months	Days	If less than one day
76	6	9	..... hrs. ..... min.

9. Birthplace Westminster R.D. Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name George Wolf

13. Birthplace Westminster, R.D. Md.

MOTHER 14. Maiden name Rebecca Petery

15. Birthplace Westminster R.D. Md.

16. Informant G. Hesson Wolf

Address 403 Monde Ave Baltimore, 25 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/45 (month) (day) (year)

Cemetery or crematory Medford Branch Cem.

Location Westminster R.D. Md.

16. Funeral director J. S. Myers Jr.

Address Westminster Md.

19. 12/1/45 (Date rec'd by registrar) H. Crawford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30th 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24th 1945 to Nov 30th 1945

and that I last saw him alive on Nov 30th 1945

Immediate cause of death Organic Heart Disease — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John D. Stewart M. D. or Other

Address Westminster Md. Date signed Dec 1st 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

10969

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County Carroll Co Registration Dist. No. 75

Village or City Manchester Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Amanda Elizabeth Wolfe

(a) Residence: No. Main St Manchester St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~ (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amos Wolfe

6. DATE OF BIRTH (month, day, and year) May 28, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House Wife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. House Wife

10. Date deceased last worked at this occupation (month and year) Sept 10, 1945

11. Total time (years) spent in this occupation 50 years

12. BIRTHPLACE (city or town) (State or country) Carroll Co

FATHER

13. NAME Jonas Royer

14. BIRTHPLACE (city or town) (State or country) Carroll Co

MOTHER

15. MAIDEN NAME Mary Law

16. BIRTHPLACE (city or town) (State or country) York Co Penna

17. INFORMANT Mrs Amos Wolfe (Address) Manchester Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Cemetery Place Meadow Branch Date Nov 10, 1945

19. UNDERTAKER David R Mantuo (Address) Manchester Md

20. FILED Nov 9, 1945 Mrs W. G. S. Benner Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH November (Month) 7 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from August, 1945, to Nov. 7, 1945

I last saw her alive on Nov. 6, 1945; death is said to have occurred on the date stated above, at 1:40 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Liver	March 1945
Other Contributory Causes of Importance: Chronic Cerebral Thrombosis	11-12 years

Name of operation Laparotomy Date of Sept. 1945

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Maurice C Partridge M. D.

(Address) Hampstead Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN